



Ten years of fertility treatment experience and reproductive options in transgender men

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ABSTRACT

Background: Up to 2018, the Belgian law stated that transgender people who wanted to change their legal sex had to undergo physical gender affirming treatment. This included gonadectomy to a medically possible and justified extent, which entailed that they had to accept the fact that they could no longer reproduce. However, research has shown that many transgender people desire to have children.

Aims: (1) to describe a cohort of transgender men and their respective cisgender female partners, to share our experiences with their request for donor conception, and to evaluate their disclosure intentions to the child, (2) to explore how the couples approach current and future reproductive options.

Methods: This mixed method study presents data from a retrospective analysis of patient records and from a qualitative interview study. The couples were selected from the group of transgender men who – together with their respective cisgender female partners – applied for sperm donation at Ghent University Hospital between 2002 and 2012.

Results: Forty-seven transgender men with a cisgender female partner requested treatment with anonymous donor sperm for a first child as a couple. Forty-one requests were accepted for treatment. We found that most couples requesting treatment intended to disclose the use of donor sperm to their future child ($n = 34$) while 24 couples were planning to inform the child about the parent's transgender identity. The six couples we interviewed saw donor conception as the preferred route to become parents. Adoption was seen as less obvious. The couples' attitudes toward stem cell-derived gametes reflected the significance of the genetic link with the child for both parents.

Discussion: Not all participants in our study were aware of their reproductive options. To be able to make a well-informed decision, transgender people should be counseled about all options at the time of transition.

KEYWORDS

Fertility; disclosure; donor conception; reproductive options; transgender men; counseling

Introduction

Up to 2018, the Belgian law stated that transgender people who wanted to change their legal sex had to undergo physical gender affirming treatment. This included gonadectomy to a medically possible and justified extent (Wet betreffende de transseksualiteit [Law on transsexualism], 2007), which entailed that they had to accept the fact that they could no longer reproduce. However, research has shown that many

transgender people harbor the wish to have children (Feigerlová et al., 2019). Wierckx et al. (2012) found that more than half of the transgender men in their group (54%) desired to have children one year after sex reassignment surgery [SRS]. Moreover, the majority of transgender men are of reproductive age at the time of transition (Kreukels et al., 2012) and engage in relationships following transition (De Cuypere et al., 2005; Wierckx et al., 2011, 2012). Most transgender men

have female partners before as well as after SRS (Nieder et al., 2011; Wierckx et al., 2011), which means they could make use of donor insemination [DI] to have children. DI treatment is often shrouded in secrecy and taboo (Indekeu et al., 2012), but for transgender people this is further complicated by possible secrecy regarding the gender transition of one of the parents. Ethical questions have been raised about the mandatory loss of fertility in the past and about whether or not to accept this group of patients for fertility treatment (Baetens et al., 2003; Brothers & Ford, 2000; De Sutter, 2003; Jones, 2000). Although empirical research is scarce, there is no evidence that accepting these couples for fertility treatment would seriously harm future children (De Wert et al., 2014; Murphy, 2010). Research in children with a transgender parent shows normal development and limited impact of the parent's transgender identity on the children's perception of parent-child relationships (Chiland et al., 2013; Zadeh et al., 2019). Various researchers have made a case for reproductive options to be discussed and offered before the start of transition (Coleman et al., 2012; De Wert et al., 2014). ESHRE's Task Force on Ethics and Law states that each request should be assessed individually and experts be consulted for advice (De Wert et al., 2014). Yet, fertility preservation options do exist and they include embryo, oocyte and ovarian tissue cryopreservation for transgender men and sperm, testicular tissue and spermatogonium stem cell cryopreservation for transgender women (Mattawanon et al., 2018). However, there seems to be a high discrepancy between the counseling for fertility preservation and its uptake (Baram et al., 2019). Factors that influence consideration of this technique are: perceived importance of genetic parenthood, willingness to delay the transition process, the confrontation with the female body, financial reasons, being a parent or desiring parenthood, and the opinion of significant others (Armuaud et al., 2017; Birenbaum-Carmeli et al., 2020; Riggs & Bartholomaeus, 2018). Moreover, under Belgian law, transgender people can apply for fertility treatment with donor gametes; they are not excluded on the basis of their transgender background or sexual orientation.

The first objective of the current study is to describe a cohort of transgender men and their

respective cisgender female partners who applied for treatment in our clinic, to share our experiences with their request for donor conception, and to evaluate the couples' intentions, at the start of treatment, with regard to disclosing their use of donor sperm and the gender transition itself to the child. The second objective is to explore how transgender men and their respective cisgender female partners approach their current and future reproductive options and how they reach a decision about these. This study is embedded in an interdisciplinary qualitative research project, pooling bioethical, psychological, and medical expertise (Provoost, 2020; Van Parys et al., 2017). The project was set up to investigate the meaning of genetic and non-genetic parenthood for families using Medically Assisted Reproduction [MAR].

Methods

Since 2002 the Department of Reproductive Medicine of Ghent University Hospital (Belgium) accepts donor conception requests from transgender men and their respective cisgender female partners. For the first objective of this study (description of the cohort, request evaluation, and disclosure intentions), we performed a retrospective analysis of the psychological and medical records of all transgender men with a cisgender female partner who requested treatment with anonymous donor sperm for a first child in their relationship between February 2002 and January 2012. This resulted in a study sample of 47 couples. All information was obtained with informed consent of the couples and was further processed and analyzed anonymously.

For the second objective of this study (decision-making and perception of reproductive options), we interviewed six transgender men together with their respective cisgender female partners. They were recruited from the same cohort that was studied quantitatively. Additional inclusion criteria were: Dutch-speaking and living in Belgium. Initially, we only wanted to include parents but because of the low number of eligible couples (seven), we adjusted our inclusion criteria and we decided to include intended parents too (four eligible couples). This led to 11 couples that were eligible for the study. Three couples refused

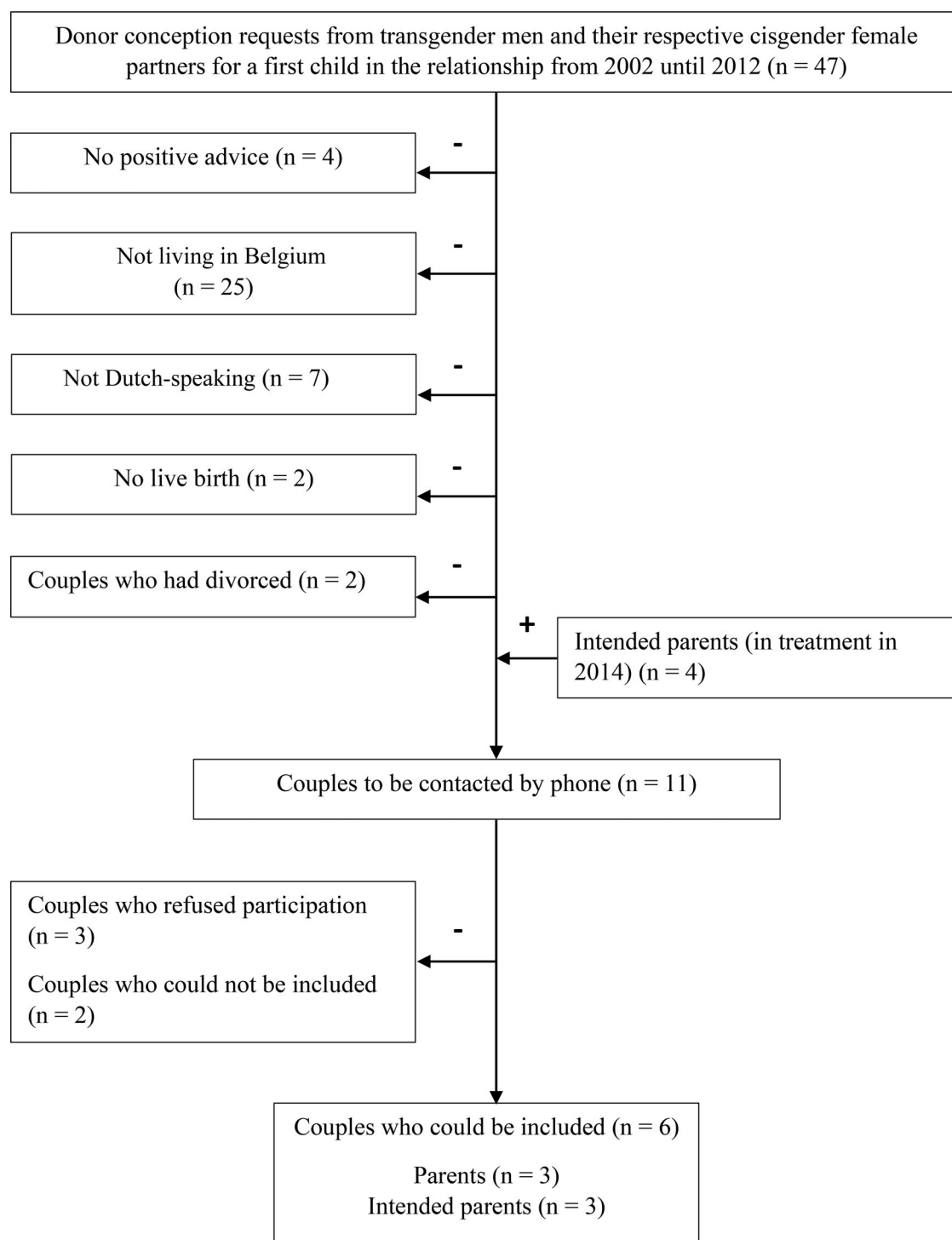


Figure 1. Recruitment process flow chart.

participation. Two other couples could not be included because they could not be reached (1), and because they did not respond after receiving information about the study protocol (1). Of the final sample, three couples had at least one child as a result of donor insemination with anonymous donor sperm (the first-born was between 7

and 8 years old) and three were either in treatment or pregnant at the time of recruitment (2014) (Figure 1).

The in-depth semi-structured couple interviews were performed between September 2014 and January 2015. Five of them were conducted by a psychologist of the research team. One interview

was performed by the coordinator of the research team who has experience in interviewing. Four reproductive options were discussed: donor conception, adoption, oocyte freezing and stem cell-derived gametes. We focused on the following questions: “Did you consider other options to fulfill your wish to have a child?” “If oocyte preservation had been an option at the time of your transition, would you have considered it?” “If a treatment with stem cell-derived gametes had been an option at the time you wished to have a child, would you have considered it?” The interviews took place at the homes of the participants, as per their request. Each interview lasted 50 to 120 minutes and was audio-taped and transcribed verbatim using pseudonyms. Transcripts were checked for accuracy by a team member and by the interviewer. Data were analyzed through inductive content analysis by the second author. The aim of this approach was to systematically code the data into categories and focus on the frequencies without missing the context (Vaismoradi et al., 2013).

Approval from the clinic’s Ethics Committee was obtained (B670201214703).

Hospital procedure

In Belgium, anonymous donation is prescribed by law but known donation is allowed. At our department a counseling session is mandatory since counseling services are considered to be an integral part of donor treatment. In counseling prior to treatment with donor gametes, the couples’ motives and concerns about the treatment are discussed as well as whether or not they intend to disclose the way their family was built to the child. Treatment acceptance at our department is based on this mandatory counseling session but also on a physical examination (performed by a medical doctor of the department) and a profound evaluation at our multidisciplinary staff meeting. In this time period, only requests from transgender men who lived as a man and had already undergone a mastectomy and hysterectomy were accepted, although transgender men who had not (yet) chosen further genital surgery (phalloplasty or metatidioplasty) could also request treatment. In principle,

requests from transgender men with a cisgender male partner or a transgender partner can be considered for treatment at our fertility center but were not included for this study.

Disclosure intentions of all couples were documented during the counseling session. The two basic disclosure questions were: (1) “Will the couple disclose the use of donor sperm to the future child?” and (2) “Will they disclose the parent’s transgender identity to the child?”. Three possible answers were: (1) “Yes”, (2) “No” or (3) “We are in doubt at this moment”. The latter indicates that there was disagreement between the partners or that they were undecided at that time. The decision of the couple was written down for further follow-up. The couple’s decision was not in any way part of the couple’s assessment prior to acceptance into the sperm donation program.

Results

Study population

Between 2002 and 2012, 47 transgender men with a cisgender female partner requested anonymous donor conception treatment for a first child as a couple. None of the transgender men had genetically related children prior to the request. Three transgender men had already a DI child or DI children in a previous relationship. Four cisgender female partners had at least one child from a previous relationship. The demographic characteristics of the study population are summarized in Table 1. The mean age of the cisgender female partners was 31 years (range 22–41 years), while the mean age of the transgender men was 34 years (range 24–47 years). The average duration of the relationship was 5.7 years (range 1–20 years). All couples lived together and 14 were married (30%). The employment status (defined as ‘having a current occupation bringing in money’) was high for both the transgender men and their partners. Most couples (60%) lived abroad ($n = 28$), mostly in France ($n = 24$). A total of 41 requests (87%) were accepted for treatment. Four couples withdrew after initial postponement because of difficulties regarding the transition process of the

Table 1. Demographic characteristics of the study population.

	Study population (N = 47)	
	Transgender men	Cisgender female partners
Age at the request for fertility treatment (years) (mean range)	34.04 (range: 24 – 47)	31.04 (range: 22 – 41)
Duration of relationship*		
≤ 5 years (n) (%)		33 (73 %)
6 – 10 years (n) (%)		5 (11 %)
> 10 years (n) (%)		7 (16 %)
Job classification		
Employed (n) (%)	40 (85 %)	41 (87 %)
Unemployed (n) (%)	7 (15 %)	6 (13 %)
Nationality		
Belgian (n) (%)		19 (40 %)
French (n) (%)		24 (51 %)
Other (n) (%)		4 (9 %)

*n = 45 (range 1 - 20 years).

Table 2. Disclosure patterns: intended disclosure of the use of donor sperm and/or the parent's transgender identity to the child.

	Intended disclosure of donor conception	Intended disclosure of transgender identity	Number (%)
Harmony in both items	Yes	Yes	24 (51,06 %)
	No	No	6 (12,77 %)
	Undecided	Undecided	6 (12,77 %)
Discrepancy in both items	Yes	Undecided	6 (12,77 %)
	Yes	No	4 (8,51 %)
	Undecided	No	1 (2,12 %)

transgender men and the use of donor sperm. Two additional demands were merely a search for information, these couples did not plan to start a fertility treatment immediately. Thirty-nine couples started treatment and 26 (67%) achieved an ongoing pregnancy. All of these 26 couples became pregnant after intrauterine insemination (on average after four cycles), except for one couple needing an IVF procedure for female subfertility reasons. After a first pregnancy, 14 couples (54%) returned for a second child. One couple started treatment for a third child.

Disclosure intentions

We found that 34 of the 47 couples (72%) requesting treatment intended to disclose the use of donor sperm to their future child. Seven couples were in doubt at that moment (15%) and six couples were convinced never to tell (13%). With respect to the parent's transgender identity, 24 couples (51%) were planning to inform the child, 13 couples (28%) were convinced not to disclose. In ten couples, the partners did not agree or did not yet know what to do (21%). Transgender men often stated during counseling that they

considered the transition period as completed and belonging to their own past, not to the child's life. Another reason for not wanting to disclose the transgender topic is that they wanted to protect the child from the social taboo surrounding it. Table 2 clarifies the intentions to disclose donor conception and the parent's transgender identity to the future child. Half of the couples had the intention to be open toward a future child about both the use of donor sperm and the medical history, although more difficulties on the subject of the parent's transgender identity were mentioned.

Reproductive options

For the second objective of this study, we interviewed six transgender men together with their respective cisgender female partners. When they made the decision to transition, the men we interviewed had to decide whether they wanted to proceed with the transition or safeguard their reproductive potential. At that time, most of them were young and did not have an active wish for a child. The one person who did consider having children was denied access to fertility treatment in several fertility centers. Another

participant proceeded with the transition because he saw pregnancy and childbirth as the pinnacle of womanhood and therefore it was not an option for him.

Donor conception versus adoption

All couples viewed donor conception as the preferred route to become parents. For three couples the cisgender female partners' strong wish to become pregnant influenced this decision. Furthermore, also for three couples, both partners wanted to be present from the start of the pregnancy which is not possible in adoption. One couple preferred donor conception over adoption because the family would resemble the traditional family more. For one couple the transgender identity of one of the partners was seen as an obstacle in an adoption process. Four couples cited the fact that the process is time-consuming as a reason for not pursuing adoption. Other reasons given for not adopting were the high requirements (e.g. high income) (1 couple), the fact that the adopting parents do not know "what child they get" (1 couple) and the low chance of being a potential donor for your child in case of medical emergencies (because of the absence of a genetic link with both parents) (1 couple). For one transgender intended parent, the wish for a child prevailed over not having children and that is why he and his partner considered adoption more and more as an option while being in the process of fertility treatment:

I have come to a point, mentally, where I want a child and. I know, it will never genetically be mine, so it, yeah. To me it doesn't matter where it comes from, then. If only I could have a child.

Oocyte freezing

Five couples talked hypothetically about oocyte freezing, since this was not an option for them at the time of their transition. Oocyte freezing was brought up at the end of each interview and the couples were asked if they would have considered it if it had been given as an option at the time of transition. The transgender participants did not consider oocyte freezing as an option because of various reasons. For two transgender men the fact that ovarian stimulation was necessary

(which implied a confrontation with the female body) was a stumbling block. Another transgender intended parent explained that at that time he did not want to keep anything from his previous body. In the interview he said:

Now I'm no longer like that. I am who I am, right. I tend to be less strict on myself. Now I know that I can still be in touch with my former self and the body I used to have.

Two transgender men stated the delay in transition process that would occur from freezing oocytes as a reason not to go through with it. The transgender men did not want to lose time because the transition was their priority at that moment (1 transgender man). Also, one person did not have a wish for a child at that time and he did not think he would ever have children. Another one did not want to pass on his genes to a child because of genetic conditions in his family. One man was offered oocyte freezing but he did not proceed with it because his future partner would provide the oocytes. The financial aspect also seeped through in his reasoning. Another participant expressed a feeling of ambivalence when he and his partner were in treatment, realizing that her oocytes were of bad quality and that he "had his healthy ovaries removed all those years ago because he did not want them". The possibility to have a genetic link with the child was perceived as a benefit of oocyte freezing for three participants. One male participant did not think a genetic link between him and the children was important but his children might not agree with that.

Stem cell-derived gametes

At the end of the interview, all couples were informed that researchers are now working on deriving sperm and oocytes from stem cells. The participants were requested to think about the hypothetical situation and were asked whether this would have been considered an option for them to fulfill their wish for a child. The participants' reactions varied from reserved over astonishment and disbelief to enthusiasm. A female participant described it as "a strange idea", "not normal" and "incredibly intervening with nature". She said that all cells have their own function

and only oocytes and sperm cells should be used for reproductive purposes. Another couple was positive on the whole but the female partner expressed her concern about the consequences of this new technique and its impact on the health of the children. However, most participants were very positive about this possible development and they would definitely consider a fertility treatment with stem cell-derived gametes. Eight participants were very straightforward about it. An intended male parent stated the following:

They can have a piece of me right away. That is something I don't have to give much thought. If that is something that can save your wish for a child, I would go for it right away.

The participants who were in favor of this technique pointed at several reasons when explaining why they felt comfortable with this innovation: there is no threat of the donor showing up someday or being somehow involved as an unknown third person (3 couples), both partners are able to have a child together (2 couples), they know where the sperm comes from (2 couples) and above all, there is a possibility for *both* parents to share a genetic link with the child (3 couples). One couple described this option as more “normal” than donor conception because the genes of the partner are used. These partners also wondered why you should look for a sperm donor when you have a partner who is willing to give some cells. Two couples thought that a fertility treatment with stem cell-derived gametes would help a lot of people and would be the first choice of many intended parents.

Discussion

The first objective of the current study was three fold, i.e. to describe a cohort of transgender men and their respective cisgender female partners, to share our experiences with their request for donor conception, and to evaluate the couples' intentions with regard to disclosing their use of donor sperm and the gender transition itself to the child.

Treating partners of transgender men has become a standard procedure at our department: no less than 87% of the requests are accepted for treatment after a multidisciplinary evaluation.

From a medical point of view, most transgender men had a cisgender female partner with good pregnancy chances and outcome.

The policy of the department is non-directive regarding the patients' choice of disclosure. Also, the couple is guided by a trained counselor. During counseling, the focus is on the process of decision-making: participants are not only encouraged to share their concerns, they also get the opportunity to gain a better understanding of their own as well as their partner's take on the situation and to consider different scenarios. Half of the couples in question expressed the intention of being open toward their future child both about the use of donor sperm as well as on the gender identity of the transgender parent. We found different levels of disclosure toward the child on the two subjects, showing higher willingness to be open about donor conception than about the parent's transgender identity. Specifically, our results showed a rather high proportion of transgender men and their cisgender female partners (72%) planning to disclose the mode of conception to their future child. No literature is available on disclosure of donor conception in this particular kind of couple. Studies examining intentions for disclosure and disclosure patterns among couples consisting of a cisgender male and a cisgender female partner who had children after DI show that the majority does not disclose the mode of conception to their offspring (Appleby et al., 2012; Daniels et al., 2009; Lycett et al., 2005). A small group of intended parents in our study was still in doubt about disclosing the mode of conception at the moment of counseling. Isaksson et al. (2012) stated that agreement on disclosure to offspring about the donor treatment was related to the quality of the partner relationship in heterosexual couples. Daniels et al. (2009) suggested that when there is agreement at the time of donor treatment or soon thereafter, that decision is likely to be adhered to. In case the couple had not reached agreement on this issue by then, or in case they remained undecided, Daniels et al. (2009) often found them to remain unforthcoming, with only one third of the couples ultimately informing their child.

We found a strong cross border trend in our study: more than half of the couples turned out to live abroad, mostly in France. Van Hoof et al. (2015) states that all causes of cross-border reproductive care can be divided into two groups: legal restrictions and availability of good quality care. A possible explanation for this phenomenon is that our hospital has an international reputation for transgender medicine. In particular, many French men have been treated there. This result is also in line with a large-scale study conducted by Shenfield et al. (2010), who found that 54.8% of patients travel for legal reasons. French patients constituted one of the groups in this study, with most of them traveling to Belgium.

The second objective of this study was to shed light on the way transgender men and their cisgender female partners approach their current and future reproductive options and how they reach a decision about these. The couples viewed donor conception as the preferred path to parenthood. Adoption was seen as more cumbersome because of the transgender identity of one of the partners and the fact that it is a time-consuming process. The importance of both parents sharing a genetic link with the child was reflected in their attitude toward stem cell-derived gametes. None of the transgender men had cryopreserved oocytes because that particular reproductive option was not presented to them, but mostly because it was no option for them at all. Thus, our findings are in line with previous research about fertility preservation in transgender people (Riggs & Bartholomaeus, 2018) and more specifically in transgender men (Armund et al., 2017; Birenbaum-Carmeli et al., 2020). Oocyte banking also implies a high financial cost and whether it can be performed or not depends on national and local regulation. Moreover, it is not a given that the frozen gametes will survive the thawing process and/or be of sufficient quality to be used for reproductive purposes (T'Sjoen et al., 2013).

Ovarian tissue cryopreservation was not discussed in our interviews, but since this technique is still experimental it does not constitute a valuable alternative to oocyte freezing. Also, the interviews were performed in 2014 and 2015, a time when ovarian tissue cryopreservation was a lot more underdeveloped than it is today. However,

this technique has the benefit that it can be offered to prepubescent girls because it is not necessary to perform ovarian stimulation (Mattawanon et al., 2018).

The results of this study support the importance of the Belgian law change. Since 1 January 2018, it is possible for transgender people to legally change their gender markers without gonadectomy (*Wet tot hervorming van regelingen inzake transgenders wat de vermelding van een aanpassing van de registratie van het geslacht in de akten van de burgerlijke stand en de gevolgen hiervan betreft* [Law regarding the reformation of arrangements regarding transgender people and the change of the registration of their gender in the documents of the civil service and the consequences thereof], 2017). This means that a transgender man can still have female gonads and thus reproduce by interrupting testosterone supplementation. This technique can also provide a solution for people who have not come of age at the time of transition. A second solution is offering a fertility treatment with stem cell-derived gametes. The general attitude toward this technique was positive because it accords well with traditional family values, more specifically with the possibility of both parents being genetically related to their child. At the moment, it is not clear if and when this innovation will become a reality.

Although the quantitative part of this study is limited by its retrospective nature and center-specific findings, it contributes to the knowledge of counseling and treatment issues about the requests of transgender men and their cisgender female partners for donor conception. Another limitation is the small sample size of the qualitative part (sic couples). For this study, the richness of the data - in particular about an under-studied topic - was more important than the actual number of participants. This study provides an insight in disclosure decisions of transgender men with a cisgender female partner in a fertility trajectory. Follow-up research is needed to determine if disclosure intentions at the time of treatment will actually be carried out in the future. Finally, all we did was to take a snapshot of the decision-making process of each couple involved. However, it is a forgone conclusion that

decision-making is a continuous and ever-evolving process that goes beyond the data one study can gather and process.

The couples viewed donor conception as the preferred route to parenthood. Adoption was seen as less obvious and oocyte freezing was mostly considered a merely hypothetical possibility. Gametes generated from stem cells were considered a valuable option for some couples. However, some reproductive options were not known to all participants involved. In order to be able to make a well-informed decision, it is advisable that transgender people receive counseling about all options at the time of transition as recommended by the international guidelines (Coleman et al., 2012).

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Disclosure statement

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